<u>Written Testimony</u>

Youth Homelessness, Youth Aging out of Foster Care, and Behavioral Health
Behavioral Health Reform and Innovation Commission (BHRIC),
Children and Adolescent Behavioral Health Subcommittee

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Good afternoon Chair Lewkowiez and other members of the Subcommittee. My name is Michael Waller. I serve as Executive Director of Georgia Appleseed Center for Law and Justice. Georgia Appleseed is a non-partisan, non-profit law center that advances justice and equity for all of Georgia's children through law and policy reform, community engagement, and legal representation of children. We focus our efforts on removing barriers to justice experienced by Black and Brown children, children experiencing poverty, LGBTQ+ children, children with disabilities, and children in foster care. Georgia Appleseed believes justice requires that every child have access to strong, nurturing schools and a stable, healthy home. Our two primary program areas are what we refer to as School Justice and Housing Justice. Georgia Appleseed's School Justice Initiative has two main strategic priorities: (1) keeping children in class and out of the juvenile justice system and (2) increasing children's access to needed behavioral and academic supports. We focus our Housing Justice Initiative on ensuring that low-income families have stable, healthy housing.

I'm speaking to you today to share legislative, policy, and best practices recommendations to better support the mental and behavioral health needs of homeless youth and youth in foster care. Georgia Appleseed listens closely to the communities we serve and our community partners. We based our recommendations on our experience providing legal supports to hundreds of children in foster care and working with communities to reduce homelessness, as well as feedback from children, youth, and their caregivers. We also researched efforts in other jurisdictions and gathered input from Georgia providers, state agencies, courts, educators, and experts who support these children and youth.

Introduction of Other Speakers: Mr. Ford, Ms. Lanier, Dr. Redd, and Mr. Jones

This afternoon, you will also hear from four community partners. Gevontae Ford will testify first. (He goes simply by "Ford."). Ford aged out of the Georgia foster care system and into homelessness almost 10 years ago. Ms. Glenene Lanier will follow. Ms. Lanier is the Placement and Permanency Senior Director with the Georgia Division of Children and Family Services (DFCS). She also happened to serve as Ford's case manager for a time while he was in care. Both Ford and Ms. Lanier could not be here in-person today. They will offer their testimony via pre-recorded video.

Dr. Alie Redd, Executive Director of Covenant House Georgia will follow. Covenant House provides housing and comprehensive supports for youth experiencing homelessness and escaping trafficking. After Dr. Redd, Chad Jones, the Vice President for Business Development at View Point Health, will offer perspective of a community service board. I will follow Mr. Jones with some closing remarks. Dr. Redd, Mr. Jones, and I will be available in-person to respond to questions.

Before we hear from Ford, I would like to share a little context. My understanding is that subcommittee members would prefer to focus our time on pragmatic recommendations. In light of that, I will not review much statistical or background information. However, please understand that our recommendations spring from an injustice that we consider fact, namely that Georgia's children experiencing homelessness and children in foster care suffer from acute and chronic mental and behavioral health needs that are not met. Georgia is failing to adequately protect and provide for these children with profound, tragic, long-lasting, and multi-generational effects. However, the recommendations that we propose today are achievable, pragmatic and increase access to the services and supports that these children need.

Ford's story illustrates the dangers these children face when they do not receive needed treatment and care. His story also proves that if we provide children and youth with the mental and behavioral health supports that they need, we can save lives and alter the course of history for their families and communities.

Ford will describe how he entered care, was misdiagnosed with schizophrenia, and did not receive needed mental health supports. Though he was a good student, he exited foster care directly into homelessness preventing his high school graduation. After he sought help and was properly assessed for his needs, he quickly passed his GED and moved towards stabilization. His story is not complete, but as you will see from his testimony, Mr. Ford is quite capable of overcoming many of the challenges that adults created for him as a child. He just needs the appropriate care and support. Ms. Lanier will emphasize that Ford's life would have been very different if he had received evidence-based assessments conducted by well-trained caregivers, trauma-informed care, and care that engaged multi-disciplinary experts working closely together. He might not have entered foster care at all if Georgia had more effective prevention policies to support parents in crisis, like Ford's mother who struggled with substance abuse.

Background: Impacts of Homelessness and Foster Care on Children and Youth

As Dr. Redd and Mr. Jones can tell you, Ford's experience is far from unique. For children aging out of the foster care system, research suggests that some 25% experience at least one episode of homelessness by age 21.[1] Indeed, homelessness impacts tens of thousands of our Georgia school children each year. According to the Georgia Department of Education (GaDOE), during the 2020-21 school year (the most recent report to be released) 31,768 children were unsheltered and/or precariously housed.[2] Homelessness and entering foster care are both traumatic for any child—and can cause or exacerbate existing mental or behavioral health

challenges.[3] These traumas may also instigate family and societal rejection, violence, emotional harm, and discrimination at alarming rates.[4] Evidence suggests, and the experience of our co-presenters corroborates, that youth experiencing homelessness exhibit disproportionately high rates of mental health conditions, including depression, anxiety, PTSD, schizophrenia, suicidal contemplation, substance use, dissociative behavior, and conduct disorder and these youth are six times more likely to meet criteria for 2 or more psychiatric disorders than their housed peers.[5] The failure to both prevent and address mental health issues can result in increased involvement with the juvenile and criminal justice systems, increased school discipline, and lower graduation rates.

Certain populations of children, particularly Black and Brown children, those with disabilities, and LGBTQ youth experience foster care and homelessness at higher rates than average, perpetuating historic and systemic injustices. [6]

Testimony from Speakers

The recommendations that we will share with you today fall into three categories. First and foremost, Georgia should emphasize prevention, aiming to ensure that children and their families have the resources they need to support emotional and physical well-being. Second, Georgia should integrate community engagement and multi-disciplinary collaboration at every stage of mental and behavioral healthcare. And third, we must ensure adequate funding for prevention, high-quality services, and the best-in-class workforce our children need.

You will now hear from Ford, Ms. Lanier, Dr. Redd, and Mr. Jones. After their testimony is complete, I will wrap up the presentation by highlighting some of the specific proposals that Georgia Appleseed and our fellow panelists propose for your consideration.

- A transcript of Gevontae Ford's testimony is available in Exhibit A.
- A transcript of Glenene Lanier's (DFCS) testimony is in Exhibit B. (The opinions expressed by Ms. Lanier are her own and do not express the views or opinions of the Division.)
- Dr. Alie Redd's (Covenant House Georgia) Testimony Report is Exhibit C.
- Chad Jones's (View Point Health) Testimony Report is Exhibit D.

Before we open up for questions from subcommittee members, I'd like to summarize our recommendations for legislation, policy, and best practices. In addition to the testimony that you have just heard, my written testimony contains the following and additional recommendations in greater detail. You can also find additional information on our website, gaappleseed.org.[7] In addition, in my written testimony, I reference related policy recommendations from Voices for Georgia's Children, The Carter Center Mental Health Program and Resilient Georgia, three partners in our effort to support Georgia children's mental and behavioral health. [8]

Recommendations

1. **Georgia should expand prevention efforts that nurture protective factors (like housing stability, supportive school environments, and healthy families) for *every child* and identify mental and behavioral health challenges before they become crises.**

    A. Expand School-Based Mental and Behavioral Health (SBBH) services to every child who needs them in every public school.

Georgia should expand funding for SBBH via the Georgia Apex Program or other funding sources. GaDOE should encourage schools to develop programming and provide technical support (as it has with Positive Behavioral Interventions and Supports (PBIS) and whole child).[9] For more information about current efforts to provide SBBH, see Georgia Appleseed's *Establishing a School Based Behavioral Health Program.*[10]

In addition to SBBH programs, there are other opportunities to create environments that build children's mental health resilience. Georgia should fully support positive education climates (school climate) programs like PBIS and renew GaDOE's commitment to school climate reform. In addition, Georgia should train every school employee in mental health awareness and trauma-informed care. The current GaDOE Mental Health Training Project supports these evidence-based trainings for schools.[11]

    B. Expand coverage of the Trauma Impact Rule to apply to children experiencing homelessness.

The Trauma Impact Rule (House Bill 855 (2021), amending O.C.G.A. § 20-2-152.2) requires schools to assess the impact of trauma on a child in foster care in the classroom.[12] The Rule's impact should be assessed, and the Rule should be amended to cover additional students, including students in homelessness.

    C. Open Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to Licensed Clinical Social Workers (LCSWs) and Licensed Professional Counselors (LPCs).

Georgia should provide a billable opportunity for behavioral health providers to screen youth and young adults who are in child welfare and/or homeless to begin diagnosis and treatment. Currently, behavioral health providers must complete comprehensive assessments and intakes to bill insurance providers, which can be lengthy and cumbersome. And, currently, only pediatricians are authorized to deliver EPSDT screenings.

D. Create new tools for DFCS to help children avoid foster care or stabilize them when they enter care.

For example, Georgia should expand respite care to provide short-term care for more children with behavioral challenges when family needs a break to relieve stress and protect family integrity. The state should also reinstate therapeutic foster care to serve children with complex needs in family setting—this type of care would help reduce the use of "hoteling."

E. Reform Transitional Living Programming for children in foster care.

DFCS and other appropriate state authorities should work closely with providers, other relevant experts, and children in care to develop new standards and requirements for programming that supports transition-age youth. In addition, the state should assess the value of greater oversight for transitional living plans for these youth, including judicial review at regular intervals.

F. Adopt a strategic plan for transition-age youth with mental health and developmental disabilities.

Georgia should establish a multi-disciplinary and multi-agency workgroup to create a strategic plan around young adults aging out of state custody and are diagnosed with both mental health and developmental disabilities. This population has been steadily growing over the past 5 years, yet there are limited long-term residential and resources available. And, in many cases, youth do not enroll or take advantage of available programs and resources because of administrative hurdles or lack of information. For example, youth may not understand that they can re-enroll into foster care (with Medicaid coverage until age 26) after aging out of care, or they fail to re-enroll within the short re-enrollment window.

G. Assess and meet the individual needs of children.

Assess and meet the specific challenges of each child. Consider whether those needs impact placement and the type of services offered. For example, LGBT and gender non-conforming youth should be placed in environments where they are accepted, supported, and encouraged to embrace their identity. DFCS should conduct an audit to determine whether all contracted service providers and programs are gender affirming, caring, and supportive of the whole child.

F. Expand housing supports for low-income children and families.

Create collaboration among agencies that provide or administer housing vouchers, tax-credit supported housing, and other housing supports for children in foster care and/or low-income families. Identify challenges to these programs and implement solutions. For example, foster caregivers report that federally funded Foster Youth Initiative Vouchers are under-utilized in Georgia. How can the state better help former students in care take advantage of this and other programming, such as Low-Income Housing Tax Credit (LIHTC) housing?

2. **Emphasize community engagement and collaboration, including to determine what services are needed and where they should be provided.**

A. Revitalize the MATCH committee and SASCCs for community-based and multi-disciplinary solutions.

At the state level, the Multi Agency Treatment for Children (MATCH) committee should be leveraged to implement BHRIC recommendations around this population.[13] At the local level, particularly in under-resourced counties, Georgia should incentivize local communities to convene the School Attendance and School Climate Committees required by O.C.G.A. § 20-2-690.2. These committees can coordinate prevention strategies and practices across schools, courts, police, and other stakeholders to support children and youth in crisis.[14]

B. Prioritize the delivery of timely services in-home or in-field where appropriate, as well as crisis services.

Georgia should incentivize providers to provide services where they are most easily accessed by children and families. Providers should engage with families and communities to identify appropriate locations for service, whether expanded telehealth coverage or in-person support in homes, schools, local YMCAs, and other public facilities. Emphasize family choice.

We should explore whether to require that Community Service Boards adopt the Certified Community Behavioral Health Clinic (CCBHC) model.[15] CCBHCs must meet specific standards for provided services and provide them quickly, including 24/7 crisis services, a comprehensive service array, and care coordination for behavioral health care, physical health care, social services, and the other systems. Funding is available via the federal Substance Abuse and Mental Health Services administration and other sources.

State agencies and community partners should increase awareness among schools and other community partners of Georgia's Mobile Crisis Services that should provide 24/7 immediate on-site crisis management through assessment, de-escalation, consultation and referral with post-crisis follow up. Accessed via Georgia Crisis & Access Line at 1-800-715-4225.

C. Use data to enhance collaborative efforts and improve outcomes.

State agencies should share data with each other and with communities as appropriate to improve collaboration and outcomes. In addition, communities should be recruited to help track problems (like encouraging the reporting of mental health parity complaints or inappropriate denials of mental health care coverage).

3. **Georgia should leverage funding opportunities to build a larger, highly qualified workforce and increase access to care.**

A. Prioritize efforts to leverage the Families First Prevention Services Act (FFPSA), enacted as part of Public Law (P.L.) 115—123.

Under the FFPSA, Georgia can apply Title IV-E (Social Security Act, 42 U.S.C. § 470 *et seq*.) funding to support families with mental and behavioral health treatment in order to prevent children being removed from their families.[16] Currently, DFCS is working on its Families First Plan and a clearinghouse for approved treatments.[17] There needs to be more urgency around this process.

B. Increase funding and reimbursement rates for case management, PRTFs/CCIs, Medicaid, and other necessary services.

Georgia should appropriate more funds to DFCS to increase the number of caseworkers, improve compensation, and improve retention, including case managers, education support monitors, and other specialists. According to recent job listings, DFCS case managers start at around $40,000 per year with a bachelor's degree. (Other DFCS staff managing intake and other critical functions may start as low as $33,000 annually). Over 55% Division of Children and Family Services (DFCS) caseworkers left their jobs last year, according to state records examined by the AJC.

The state should also increase spending rates for Psychiatric Residential Treatment Facilities (PRTF) and Child Caring Institutes (CCI) to expand intensive and creative programming to better serve young people. Increased PRTF and CCI funding would also reduce the current state custody 'hoteling' challenge since more PRTFs and CCIs could accept youth.

Medicaid reimbursement rates should increase. Georgia should also explore how an increase in the minimum medical loss ratio (MLR) would increase access to mental and behavioral health services and adjust the ratio to maximize service delivery.

Reimbursements and funding should cover more of the cost of providers' administrative oversight.

Georgia should adopt strategies to increase the number of behavioral health providers certified to treat trauma and other complex behavioral health needs, by increasing training opportunities that are cost covered for the provision of evidence-based therapies like Eye Movement Desensitization and Reprocessing (EMDR) and Dialectical Behavioral Therapy (DBT).

C. Adopt policies to make reimbursement for providers more reliable and timely.

Georgia should make funding for services easier to access by reviewing and making necessary reforms to state contracting procedures, and ensuring that payments to providers are timely. Providers report that the state often makes payments months late.

D. Explore new sources of funding.

The Georgia Department of Community Health (GaDCH) should explore new approaches to funding housing and other prevention strategies. For example, GaDCH could submit a Medicaid waiver to provide for certain health-related social needs (HRSN), like housing and food support, for children aging out public systems (DFCS, Georgia Department of Juvenile Justice, and psychiatric institutions). Program criteria should contain specific, consistent guidelines regarding services that are covered. Other jurisdictions can provide new ideas, e.g., Oregon has a Medicaid waiver that funds housing support to populations in transition.

Chair Lewkowiez and other members of the Subcommittee, thank you again for the opportunity to share these recommendations with you today. My fellow panelists and I look forward to answering any questions you might have.

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[1] *See* U.S. Dep't of Health & Human Servs.: Admin. for Child. and Fams. & Child.'s Bureau: Admin. on Child., Youth, and Fams,, *Outcomes Data Snapshot: Ga.* FY 2017-2021*, Nat'l Youth in Transition Database (June 2022), https://www.acf.hhs.gov/sites/default/files/documents/cb/nytd-outcomes-ga-2021.pdf.

[2] *See* Ga. Dep't of Educ. McKinney-Vento Program, *Title IX, Part A 2020-2021 Ann. Report*, McKinney-Vento Educ. for Homeless Child. and Youth (EHCY) (Apr. 2022), https://www.gadoe.org/School-Improvement/Federal-Programs/Documents/McKinney-Vento/Annual%20Report%20-%20FY21%20McKinney-Vento.pdf.

[3] Peter Tarr, Ph.D, *Homelessness and Mental Illness: A Challenge to Our Society*, Brain and Behavior Research Foundation (Nov. 2018), https://www.bbrfoundation.org/blog/homelessness-and-mental-illness-challenge-our-society.

[4] *See* The Annie E. Casey Found., *supra*, n.3; Morton, Samuels, Dworsky, & Patel, *supra*, n.3.

[5] Homeless Pol'y Rsch. Inst., *Mental Health Among Youth Experiencing Homelessness*, Youth Mental Health Literature Rev. (2019), http://socialinnovation.usc.edu/wp-content/uploads/2019/08/Youth-Mental-Health-Literature-Review-Final.pdf.

[6] *See* The Annie E. Casey Found., *Preventing and Ending Youth Homelessness in Am.*, A Thrive by 25 Brief (Mar. 2023), https://assets.aecf.org/m/resourcedoc/aecf-youthhomelessness-2023.pdf; Matthew Morton, M. G. Samuels, Amy Dworsky, & Sonali Patel, *Missed Opportunities: LGBTQ Youth Homelessness in America*, Voices of Youth Count – Chapin Hall at the U. of Chi. (2018), https://www.chapinhall.org/wp-content/uploads/VoYC-LGBTQ-Brief-FINAL.pdf.

[7] *See* https://gaappleseed.org/behavioral-health/

[8] Georgia Appleseed collaborates with a wide variety of partners to expand access to children's mental and behavioral health, in particular Voices for Georgia's Children (Voices), The Carter Center Mental Health Program, and Resilient Georgia. These organizations have excellent policy recommendations relevant to today's testimony. Review Voices' behavioral health policy recommendations at https://georgiavoices.org/wp-content/uploads/2023/01/BH-Continuum-FINAL.pdf. For more information about The Carter Center's work visit https://www.cartercenter.org/health/mental_health/public_policy/school_based/index.html. Resilient Georgia provides policy scans and briefs at https://www.resilientga.org/reports-briefs.

[9] *See* Ga. Dep't. of Educ., *Positive Behavioral Interventions and Supports*, Teaching and Learning – Special Education Services and Supports (2023), https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Special-Education-Services/Pages/Positive-Behavioral-Interventions-and-Support.aspx.

[10] *See* Ga. Appleseed Ctr. for Law & Just., *Establishing a Sch.-Based Behav. Health Program*, https://gaappleseed.org/resource/establishing-a-sbbh-program/.

[11] Ga. Dep't of Educ. & Reg'l Educ. Serv. Agencies, *Mental Health Awareness Training 2023-2024 Course Catalog*, A RESA/GaDOE Collaboration (2023-24), https://mhatgeorgia.com/mhat-course-catalog-2023-2024/.

[12] *See* Ga. Appleseed Ctr. for Law & Just., *WHAT IS THE TRAUMA IMPACT RULE?*, https://gaappleseed.org/resource/trauma-impact-rule-summary/.

[13] 2022 Ga. Laws, p. 67, § 5-1(28) (creating Multi-Agency Treatment for Children (MATCH) team to "facilitate collaboration across state agencies to explore resources and solutions for complex and unmet treatment needs for children in this state and to provide for solutions, including both public and private providers").

[14]*See* Ga. Appleseed Ctr. for Law & Just., *Student Attendance and Sch. Climate Comm.: Updated Res. for Success*, https://www.gadoe.org/wholechild/Documents/Student%20Attendance%20and%20School%20Climate%20Protocol%20Committee%20Considerations%202019.pdf.

[15] Substance Abuse and Mental Health Services Administration, *Certified Community Behavioral Health Clinics (CCBHCs)*, Programs (2023), https://www.samhsa.gov/certified-community-behavioral-health-clinics.

[16] *See* Bipartisan Budget Act of 2018, 115 P.L. 123, 132 Stat. 64.

[17] Ga. Div. of Fam. & Child Servs., Family First Implementation Update, Blueprint for Family First (Dec. 2022), https://dfcs.georgia.gov/document/document/family-first-implementation-update-december-12-2022/download.

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Exhibit A

Gevontae Ford, Testimony Transcript

Testimony Transcript: Gevontae Ford

I was five years old when I came into care. I know my mom, she was on, she was abusing drugs, but she was trying to get clean. But she wasn't doing it fast enough that the government felt, you know, it was enough to keep the child in the situation. So, the basic case worker came to the house trying to convince me to leave. But I remember closing the door on they face the first day. But the second day they came and said they was friend of the family and asked me do I want to go to Chuck E Cheese?

My first foster parent, I wouldn't say she was a bad foster parent. She just wasn't the most social foster parent. I grew up not really knowing much or doing anything, just doing the basics, you know, going to school as a kid and then coming home. That lasted around to maybe 11 or 12, then I left there and I was in a bunch of different foster homes.

Yeah, I just locked up. Because I was the type that I didn't really like to be around people a lot because I feel comfortable by myself. So, I was diagnosed with schizophrenia and I was getting a bunch of pills, like Adderall and a bunch of other. I don't remember, but they didn't really do nothing but make me feel horrible. Like, they would help me focus, but like I'm still hyper, but I'm sitting down. I didn't like it. It was like being a zombie.

I know, even when I was younger, the first things that I was ever hearing about DFCS was, "Oh, they understaffed or they don't have enough people to do so and so." So even when I did, the times I did see a caseworker, I never had them for long. I don't think I ever had an attorney just for me. And if I did, I was never contacted by one.

I believe from 16 up I was with a foster parent who, she treated me like in-home help. Yeah, mostly I was there as a handyman. I was there to do stuff like, cut the grass, whatever. I didn't mind, but I didn't like, to me, I didn't like the constant threats of "No, I don't have to ward you in any way. You do this or you know you're getting close to aging out. So do this or get out."

I got tired of hearing that a lot, and when I was around 18, she started piling up things that she wanted me to do. Like I started helping with roofing, the tiling and stuff like that. And I was like, I don't want to do this especially for free. Because if you're good at something, always thought you know at least you pay for it. So, I was like, “Nah, I'd rather be homeless than that.” But she took that comment literally. So I ended up homeless.

School life always seemed much more peaceful than home life. So, you know, when I was at school I would like to do something, more like read or relax, but still I ended up completing school all the way to high school. But I wasn't able to finish high school due to being homeless.

In one place I was living was on an abandoned playground. I know a few stores down there was a mattress store. Whenever they got new stuff like new carpet, they threw out the old one. So, it’s kind of embarrassing, but I used to roll up the carpet and live inside those.

I didn't know it at the time, I was depressed a lot when I was little. Even if I wouldn't have took it, something simple as, "Do you want to help with this?" would have been would have been great. I believe the best starting help could be mental help because, I can only speak from my experience. I had the drive, just not the backing to do it.

I got with Hearts to Nourish Hope and I started getting my life back together. I went and got my GED. I passed that really fast though. If it wasn't for Hearts to Nourish Hope, and Miss Nicole, who I met later on, she gave me the choice. She asked me, did I need help? In the past, usually that was code word for people that just wanted be nosy. But for once I was like, you know what? I actually do need help. But I'm glad I did ask for help because I wouldn't be right here.

Behavioral Health Reform and Innovation Commission

Exhibit B

Glenene Lanier, Testimony Transcript

Testimony Transcript: Glenene Lainer

Hi, my name is Glenene Lanier and I serve as the Placement and Permanency Senior Director for the Division of Family and Children Services and I served in this role for close to two years. But I've been with the Division for 29 years.

At one point I did, I was Gevontae's case manager and I worked with Gevontae and his family. And Gevontae mentioned his plight. He talked about some challenges that he experienced in terms of his mental health needs, having an appropriate caregiver who understood his trauma, the needs that he had regarding his mental health, his emotional health and physical health and that he feels, or felt, were somewhat unmet, which resulted in him being homeless for a time.

And I will share that as a caseworker during that time I remember having a case load as high as 55. Many of the children that enter foster care have already suffered some type of trauma prior to entering care. And even with them, with the child entering care, removals in and of itself can be emotionally traumatizing for a child. I think we, often times, as a system, misdiagnose children or the assessment is inappropriate because the child is acting out as a result. That child could be moved as a result of not having an appropriate or having a way to manage their feelings or their trauma in a way that we as adults understand what they're messaging to us. So as a result, that child could be moved to another placement which compiles the trauma that child is going through, with managing through another move.

There are opportunities for us to try to maintain these kids in their homes. I think the Family's First Prevention Act is a good step in the right direction for us to utilize an evidence based approach. If we can't prevent a child from coming into care, when that child enters care, that child is connected to a caregiver who is trained and can appropriately work with the birth family and the child to successfully work that child either to reunification or to some other successful or positive permanency outcome for that, for that child. There's an opportunity for us to look for a multifaceted or multidisciplinary way of working with families.

DFCS is, and should be, one partner at a much larger table. We have the Department of Public Health, Department of DBHBB, DJJ, the school system, and the court system. There are other resources and opportunities for us to collaborate, to work with these families prior to these kids, even after these kids come into care, for us to work together in partnership to appropriately manage supports, manage these families towards a successful outcome.

And also, just having a trauma informed caregiver. Gevontae mentioned his perception of what he experienced with his caregivers while in foster care and feeling like he didn't have a voice in his overall case management. And I think that is still an opportunity for us, given the fact that we have such high turnover in the field, that we still struggle with having some case continuity, caseworker continuity between children who remain in care for a very long time. We have the challenge of appropriately distinguishing between delinquent behavior, behavior that's truly mental health related and a behavior that's a result of some type of trauma that the child has experienced.

I think we're struggling with that as an agency. Kids that can't effectively express how they're truly feeling and so they act out in a negative way, and we have a response that's not trauma informed for that child. And as a result, that could be another move or that child could be incarcerated. And I think that goes back to having an appropriate assessment. Or having a skill set where we can connect to someone if we don't have that skill set, that we can partner with as

an agency to adequately determine how best to manage the service array for the youth that we're trying to prevent from coming into care, or the youth that's actually coming into care.

Working systemically to manage the mental health needs of both our children and our families is a step in the right direction for our agency and would ultimately, I believe, result in youth being more successful, families being reunited and could possibly reduce the outcomes such as what Gevontae shared with us today. Thank you.

Behavioral Health Reform and Innovation Commission

Exhibit C

Dr. Alie Redd, Testimony Report

Who is Covenant House Georgia?

Covenant House Georgia supports youth experiencing homelessness and escaping trafficking ages 16 to 24. We provide emergency, short and long-term housing, but we are more than a shelter providing comprehensive services including outreach, intensive case management, mental and physical health services, work force development and academic supports to name a few. It is widely known that 50% of youth aging out of foster care will experience homelessness within six months and 1 in 5 youth experiencing homelessness will be approached for trafficking within 72 hours. The youth aging out of foster care in Georgia and the youth supported by Covenant House Georgia are similar.

Who is Dr. Alie Redd?

Dr. Alie Redd joined the Covenant House team in March 2018 and comes with 28 years of experience in the field of social work. Most recently, Dr. Redd served as the Vice President of Placement Services at CHRIS 180, overseeing the organization's therapeutic group homes, street outreach, community housing, permanent supportive housing, transitional living programs, drop in center, and related supportive services. Before her time at CHRIS 180, Dr. Redd worked for Lutheran Services of Georgia. She has served various populations as a direct service provider, clinician, clinical supervisor, advocate, advisor, administrator, and executive leader. Dr. Redd earned a BA in Psychology from the University of Memphis, an MSW and PhD in Social Work Policy Planning Administration and Social Science with a cognate in Public Administration from Clark Atlanta University. She has been continuously licensed as a Licensed Clinical Social Worker since 2000. Her areas of research interest include: social and child welfare policy; commercial sexual exploitation of children; secondary trauma of social workers; refugee and immigration; racial identity; youth homelessness; and military families.

Recommendations to the Commission

At least 40% of youth experiencing homelessness and escaping trafficking experience moderate to serve mental health needs, especially in the areas of PTSD, major depression, anxiety, and attachment disorders. These needs are consistently not met for many years, if ever, because of the lack of stability of placements in foster care, homelessness, and mental health challenges, which exacerbates the youth's challenges when transitioning to adulthood and self-sustainability. When the youth's mental health is unstable, they are unsuccessful engaging in education, workforce development, employment, healthy relationships, securing stable housing; and managing their physical health putting them at risk for long-term instability and disastrous outcomes.

Solutions:

1. Support preventative mental health strategy which includes stable, healthy housing; mental and physical health supports; positive learning environments; education; and workforce development can prevent mental health challenges that lead to these disastrous outcomes which includes generational poverty.
2. Make funding for services easier to access by reforming state contracting procedures:
    a. Awardees should be notified of approval prior to the start date of the contract as to properly prepare for program;

    b. Release funds timely to providers (State often makes payments months late);
    c. Fun administrative oversight (indirect expenses); and
    d. Fund at 100% of programming costs which decreases the burden on the provider to run the programs and fundraise to cover the gap of actual costs.
3. By increasing the timelessness of approvals and access to services, Medicaid wait lists and service times are shortened. Set the bar or expectations of approval times.
4. Allow for in-home services and requiring collaborations and partnerships to form so that utilization of space and infrastructure, which is already built into their home communities (e.g., YMCAs, community centers, libraries, schools, etc.), with proper safeguards will increase access to services.
5. Emphasize family choice and community engagement whereby the family should help identify their needs in partnership with the provider so that location, dates/times, and how to best deliver services focuses on supporting the family in the best way possible.

Behavioral Health Reform and Innovation Commission

Exhibit D

Chad Jones, Testimony Report

Jennifer Hibbard, Chief Executive Officer

Behavioral Health Reform and Innovation Commission
Testimony Report

Who is View Point Health?

View Point Health (VPH) is a Community Service Board (CSB), operating as a 'safety net' provider, and offering recovery-oriented services to most-in-need individuals with mental health, addictive disease, and developmental disabilities. VPH serves individuals who are uninsured, underinsured, low-income Medicaid, aging/elderly Medicare, and veterans. View Point Health annually serves over 16,000 individuals across multiple locations in a full continuum of behavioral health services. VPH remains on the cutting edge of healthcare transformation - adapting and adjusting practices to provide high-quality care in the most cost-effective manner.

Who is Chad Jones?

Chad Jones is the Vice President for Business Development at VPH. Chad has been serving at VPH for over twenty (20) years in various capacities, including, but not limited to intensive community services, criminal justice reform initiatives, varying housing programs and youth and young adult services. Under youth and young adult services, Chad is responsible for the statewide High Fidelity Wraparound program, school-based behavioral health (Apex) project, supportive education and employment and child welfare services.

Recommendations to the Commission

- More training opportunities that are cost-covered for specialized modalities such as Eye Movement Desensitization and Processing (EMDR), Dialetical Behavior Therapy (DBT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). These therapies are not widely utilized throughout Georgia, yet have solid efficacy with youth and young adults in child welfare.
- Increased and flexible spending rates for Psychiatric Residential Treatment Facilities (PRTF) and Child Caring Institutes (CCI) that allow for intensive and creative programming (as mentioned above) to better serve this population. This would also assist in reducing the state custody 'hoteling' challenge since more PRTFs and CCIs would be likely to accept these youth.

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- Establish a small and short-term workgroup to create a strategic plan around young adults who are aging out of state custody and are dual-diagnosed with both mental health and developmental disabilities. This population is steadily growing over the past five (5) years, yet there are limited placement and long-term resources available.
- Leverage the Multi Agency Treatment for Children (MATCH) committee to support and implement BHRIC strategies around this work and population.
- Open up Early and Periodic Screening, Diagnostic and Treatment (EPSDT) to LCSWs and LPCs to give a billable opportunity for behavioral health providers to screen, diagnosis and start treatment for youth and young adults who are in child welfare and/or homeless. Currently, behavioral health providers have to complete comprehensive assessments and intakes in order to bill insurance providers, which can be lengthy and cumbersome. This allows for a quicker access to care. Right now, EPSDT is only authorized by Pediatricians.
- There needs to be intentional focus on Families First Prevention Services Act (FFPSA), specifically utilizing Title IV-E funding to create more opportunities for reunification. FFPSA allows for both youth and caregivers to receive necessary treatment in order to achieve needed outcomes so that reunification can occur. Currently, DFCS is working on a clearinghouse for approved modalities; however, there needs to be a bit more urgency around this process and more creative strategies permitted inside the clearinghouse such as High Fidelity Wraparound and the like.